Oxford could be eye of new storm against DTCs

Staff at Oxford’s Eye Hospital, situated in the city centre Radcliffe Infirmary, have decided to mount a campaign to defend its services against possible cuts and closures.

The threat to the specialist service which covers a wide catchment population throughout the Thames Valley stems from the announcement of plans to open a new, privately-run Diagnostic and Treatment Centre to deal with over 7,000 day and outpatient cataract operations over a 3.5 year period – patients currently treated in the Oxford NHS unit.

Using government plans, the cash (around £750 per case) would follow the patients – leaving the Eye Hospital with just half its current £5m a year budget, but retaining the responsibility to care for thousands of more serious and chronic eye conditions which do not offer easy profits to the private sector.

The Eye Hospital had already put plans in place to meet the government’s tough new targets on reduced waiting times, and the local Primary Care Trusts have made clear their preference to keep services where they are.

The decision on DTCs has been forced upon Oxford from national bureaucrats at the Department of Health who have demanded local health chiefs do the same.

Ministers have given a commitment to establish some 26 privately-funded DTCs, and is now insisting that cash must be diverted from existing services.

(continued on page 2)
WHEN is a private hospital not a private hospital? When it is an Independent Sector Treatment Centre – the cloy new official government-speak for a chain of 20 NHS-run DTCs which were approved by Health Secretary Alan Milburn and run previously known as Diagnostic and Treatment Centres (DTCs).

But while 20 NHS-run DTCs have been quietly established and run units previously known as Diagnostic and Treatment Centres (DTCs).

However, in 2004, to backfill off their privatization of public care, the campaign will initially focus on the Eye Hospital with a picketing on October 25, which is supposed to be a big public meeting and

The companies set to coin it in from 5-year contracts to run DTCs are:

1. Care UK Alcon – a link-up between Care UK, which runs nursing homes, and Alcon, a British Oxygen subsidiary running 66 private hospitals in South Africa
2. New York Presbyterian – 2 centres Stannome and Somererset
3. Netcare UK – a South African company – will run a centre in Manchester and two mobile ophthalmology units
4. Care UK Alcon – a link-up between Care UK, which runs nursing homes, and Alcon, a British Oxygen subsidiary running 66 private hospitals in South Africa
5. The nationally-negotiated contracts are to be drawn up on a "play or pay" basis, meaning that the PCTs are required to pay the full contract price to the DTCs over the 5-year period, even if the NHS sends fewer patients for the procedures involved.

The profit-seeking DTCs will scoop up a share of the projected caseload of 250,000 procedures a year which would be delivered in this way – 135,000 extra operations, and 115,000 treatments diverted from existing NHS units. Those profits are guaranteed. The nationally-negotiated contracts are to be drawn up on a "play or pay" basis, meaning that the PCTs are required to pay the full contract price to the DTCs over the 5-year period, even if the NHS sends fewer patients for the procedures involved.

Of the preferred bidders announced in September, five are from overseas – from Canada, South Africa and the USA, and two British. They will treat only non-urgent cases where waiting times have been a problem, including orthopaedics (hip and knee replacements), ophthalmology (mainly removal of cataracts) and minor general surgery such as hernia and gall bladder removal. The private units will have no obligation in terms of after-care: and they will be able to fix their own terms and conditions: it is already clear that they will be offering consultants four or five times the amount currently paid to NHS consultants.

While Ministers claim DTCs will be paid the same cost as per case at NHS hospitals, it is clear that they will concentrate on the most profitable and simple cases, leaving the NHS with an increasingly expensive caseload.

And the DTCs start-up costs will be subsidised – giving them a greater chance of generating a surplus. Unlike NHS units such as the Oxford Eye Hospital, where the revenue from cataract operations helps underwrite the running costs of a department delivering a full range of services, any profits plus created by DTCs will simply be pocketed as profit by shareholders.

The opposition to the plans has been widespread. Private hospital chief is miffed that we are leaving them out and run instead of filling up their existing empty capacity. They shadow health minister Liam Fox has said the contracts are too excessive.

Almost all organisations representing health staff have opposed the new private centres: UNISON warned that they will drain resources and staff from the NHS. The BMA has said that the DTCs could destabilise the NHS.

The Association of Surgeons in Training warned that the centres could do lasting damage. Even the Royal College of Nursing expressed concern over the plans: NHS units have responsibility for training doctors and nursing staff, and are under the need to maintain a broad mix of routine and more complex cases to ensure that junior doctors gain the necessary experience: DTCs by creaming off a huge share of the routine work will destroy this balance, while simply poaching the staff already trained.

Mr Barmby, worse, despite the talk of an NHS Plan, the proposals for DTCs have run alongside government targets and pressure on local Primary Care Trusts and Hospital Trusts to reduce waiting times to a maximum of 6 months by 2005. There has been even an injection of new cash into the NHS to enable it to expand its own waiting lists.

Now, just as some of these investments are starting to deliver, a small group of bureaucrats at national level have announced where the new private sector DTCs are to be. Only bankrupt Bristol PCTs have been allowed to back out: other local health commissioners have been given no say: and in the case of Oxford ophthalmologists, micromanage the PCTs that have objected have been slapped down.

The Oxford order

New private DTC is not needed!

DTCs: turning your NHS into a little earner

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The Oxford eye hospital has been working to a plan of expanding its capacity to treat cataract and reduce waiting lists for 3 months by December 2004. Consultants point out that there is no capacity gap in Oxfordshire – in fact we can demonstrate over-capacity." A DoH document on Capacities and Conventions made to reference to Oxfordshire.

Rather than providing extra capacity to treat patients, the new DTC will transfer up to 50% of NHS cataract patients into the private sector, at a higher cost.

According to top consultants at the Eye Hospital, the consequences is likely to be:

Removal of capacity to screen and treat patients with other eye problems, many potentially more sight threatening than cataract.

The Eye Hospital would be left with a more complex and expensive caseload.

Questions over the viability of on-call services, A&E services and specialist services

Training and research – which requires a minimum caucunion – striched by the danger of losing accreditation for training

To possible to recruit a Professor, undermining the acadeic department

No crunch for patients, since the full DTC contract would be not paid for, regardless of how many treated

Redundancies among nursing, admin and other staff.
IN ANOTHER example of chaos in the NHS, it appears that capacity for heart surgery has expanded faster than demand – leaving some highly expensive surgical units searching for patients.

Waiting times have fallen as more resources have been pumped into the NHS, reducing numbers waiting more than six months for heart surgery from over 4,000 two years ago to just 375 this summer. By December it is likely to be zero.

In London the 95-bed Heart Hospital, controversially bought from the private sector by University College London Hospitals Trust, has run out of work. The trust, recently volunteered to treat the entire national cardiac waiting list over 6 months. The success story on slashing waiting times combines waiting list over 6 months.

Confusion reigns as ministers axe CHCs

With Community Health Councils due to close in December, and many CHC staff leaving early to find alternative jobs, the plans for the government’s alternative structures to replace them are a total shambles.

A recent survey of the so-called “Patient Advocate and Liaison Services” (PALS) across the country showed that less than a third could offer an immediate and satisfactory response to even a simple patient enquiry. Of 100 Trusts which claimed to have a PALS service in place, in only 87 did the switchboard connect a caller correctly to the PALS service. Only 51 of these calls were answered by a person rather than an answering machine, and of these only 28 could answer the simple question.

Trusts are only obliged to fund a minimum of one member of staff in a PALS service – well short of the extensive and professional support available from the old CHCs.

Meanwhile the establishment of a network of new Patient and Public Involvement Forums, to be set up in local Primary Care Trusts, is only just getting under way, with a half-baked campaign boasting chicken which demands “make time for health”.

They won’t need to make much time: Foundation Trusts will not have PFTs, and since all Trusts are allegedly going to be Foundations within five years, they will probably have a shelf life not much longer than real chickens.

Meanwhile the Boy Scouts are among the ragbag of 140 voluntary sector organisations that have been given contracts to provide admin support for the new PFTs. Others include Citizens Advice Bureaux, charities such as Age Concern and a new organisation formed by a former CHC chief executive.

“Scout Enterprises Western Ltd” will provide services for 20 PFTs in southern England.

Camp fires and woggles will no doubt be available on demand, while ministers are left to grip the NHS by the ging-gang goolies, and health workers struggle by on little more than a Bob a Job.

Foundation Hospitals, private Diagnostic and Treatment Centres, PFI, LIFT, financial flows ...

Dragging the NHS BACK to MARKET

What can campaigners do to stop the rot?

- TONY BENN
- Prof Allyson Pollock, University College London
- Margie Jaffe, UNISON Positively Public campaign
- John Lister, London Health Emergency

A special meeting to mark the 20th anniversary of the launch of London Health Emergency as an independent organisation campaigning for the capital’s health services.

It will look forward to the next stage of the fight to defend services and health workers against growing threats from the private sector and a new market system, and uphold the principles of the NHS as a public service provided free at point of use and funded from taxation.

Contact London Health Emergency:
Unit 6, Hebburn Court, 135 Latimer Rd, London W10 6RA
020 8966 6666
email health_emergency@elga.net
www.healthemergency.org.uk

THURSDAY
October 16
7.30pm Friends House
Euston Road WC1
(opposite Euston station)
Open for all, especially health workers and campaigners.
Nursing home bosses bid to jack up fees

Social services braced for “bed-block” fines

CONCERN is growing among council chiefs whose social services face fines if they fail to deliver additional services to facilitate the swifter discharge of frail older patients from hospital. The latest estimate suggests that 3,500 of the frailest older people aged over 70 are currently trapped in acute hospital beds for lack of suitable alternative accommodation or supporting services. Many of these patients have complex needs, requiring nursing home care.

The new fines are operating in “shadow” form from October, and due to come into force in earnest from January 2004. Councils will have to pay a daily fine of £100 (£120 in London) for any person who has been assessed as ready for discharge from hospital but not found a place in a nursing home within three working days. Councils have been given just 60 days to find suitable accommodation and to secure additional accommodation – and ministers claim that many should be able to pay less in fines than they receive in grant.

However the fact that nursing homes are in the private sector, and mostly run for profit, means that neither councils nor the NHS can fully control the numbers of places.

Far from opening more places, many nursing homes are closing down and setting up, while others are holding out for increased weekly fees from councils for the clients they accept.

Analysts Lang & Bission estimate that more than 13,000 nursing home places have closed in the last 15 months, leaving the country with 74,000 fewer places than in 1996. Some councils in areas of severe shortages are reportedly investigating the prospect of opening homes themselves.

In Suffolk, nursing home proprietors, spotting their barrier of clients, have increased their fees.

The problems have been compounded by the lack of investment in modern information systems, facilities, and sufficient social workers to support the “single assessment process” that is supposed to bring together relevant professionals – social workers, nurses, therapists and housing officials – to gauge patient’s needs and prepare the process of discharge.

Meanwhile members of the Royal Commission which three years ago recommended the abolition of all charges for older people receiving continuing care in nursing homes in England have reiterated their call on the government to implement this policy in full: at present clients receive only limited nursing care funded by the NHS, while “social care” is still subject to means-tested charges.

In West London, Ealing PCT is struggling to resolve a £6m deficit in its budget and increased charges is being imposed.

North West London Hospitals UNISON congratulates London Health Emergency on 20 years of campaigning to defend our NHS.

THE FINANCIALLY and managerially challenged Barnet and Chase Farm Hospitals Trust is trying to place a nervy local public as it seeks to “rationalise” hospital services across a sprawling and congested catchment population in NW London.

The Trust needs to clear a massive inherited debt and improve performance, but Trust bosses want to replace Chase Farm with a new PFI-funded hospital, while avoiding “duplication” of services at Barnet, 5 miles away.

Bosse at Hillingdon Hospi-
tal, west London have been forced to board over a parish 30 foot long yellow orange red and pink mural painted on the wall in the hospital entrance – costing £25,000.

One female consultant complained that it gave her a headache: others have been outraged at the cost of the art, which is strongly reminiscent of graffiti routinely scrawled off the carriages of tube trains.

Carrillion has won the contract to build a new 1,200-bed PFI hospital in Portsmouth. Though the final deal has not yet been concluded, the project will cost a minimum of £1 billion over the next 35 years.
The essential points about Foundation Trusts

- Foundation hospitals will be run by boards of governors and directors, and will be responsible for developing and running the new enterprises.
- They will be able to have their own bank accounts and set up their own companies.
- They will be free to fix local pay and conditions.
- They will be able to self-fund via sales of their units.
- They will be able to borrow money either within their own institutions or to build new enterprises.

So much for all that talk about democracy and local control...

Doubts over new rights to borrow

The rush to found foundation hospitals is under way... but will the leading candidates be the ones with the new freedoms?

Not such a big deal?

Just 7% of NHS chief executives think foundation hospitals will be a significant policy change in the next five years, according to a Mori poll.

However two thirds of them thought foundation status would change the overall management within the NHS, and almost half thought it would result in more freedom for managers.

The survey for the NHS Confederation put foundation status at the bottom of the list of important changes, which was topped by the Patient Choice policy.

The biggest management challenge was seen as achieving financial stability.
You can pack a lot into 20 years – and the pace was often frantic as LHE set out to make itself useful to local campaigners and union activists across the country.

We have too little time and space here to do more than refer to some of the landmarks in two decades during which LHE, working with a crucial cross section of union activists, MPs, councillors, pensioners and campaigners helped set the agenda and challenge every attack on the NHS and its underlying principles.

Our thanks go out to all those who have supported LHE, and helped us survive the various and repeated attempts to close us down. We hope we have sufficiently repaid the favour.

**London Health Emergency**

- **1983**
  - London Health Emergency formed with GLC funding to link campaigns and raise profile

- **1984**
  - Health Emergency paper launched as a monthly, circulation 14,000

- **1985**
  - Barking Hospital strike leads a wave of struggles against privatisation of ancillary services
  - Save West London Hospital (SWEL) campaign launched

- **1986**
  - Night nurses in Manchester walk out in unofficial strike over pay
  - Expose pamphlet "I was a Mole in Medicine" published

- **1987**
  - Winter 1987: LHE’s consultants’ petition against cuts backed by 1,200 doctors in 160 hospitals

- **1988**
  - GLC abolished: LHE funding eventually taken on by a consortium of London boroughs

- **1989**
  - 1989: LHE works with West Berkshire campaigners to fight closures of NHS geriatric beds

- **1990**
  - Thatcher unveils White Paper setting out market-style “reforms”
  - LHE publishes London round-up: “Hitting the Skids - Health Service Journal comments: “The picture presented by London Health Emergency is of course presenting a picture of an area which does not exist in the health service. The London area on which it bases its figures is simply the innermost districts of the four Thames regions. “However there is a growing belief that the type of analysis offered by LHE is rapidly going to become where the goalposts will be placed as far as the London debate goes.”

- **1991**
  - Campaigns across the country oppose hospitals “opting out” to form the first wave of Trusts.
  - LHE distributes thousands of leaflets, stickers, car stickers and pamphlets

- **1992**
  - LHE supports King’s Fund call to axe 5,000 beds in London’s hospitals

- **1993**
  - LHE infuriates government by leaking key findings of Tomlinson Report to national press the night before publication

- **1994**
  - LHE opposes government by leaking key findings of Tomlinson Report to national press the night before publication

- **1995**
  - LHE produces London Health round-up “Hitting the Skids” - Health Service Journal comments: “The picture presented by London Health Emergency is of course presenting a picture of an area which does not exist in the health service. The London area on which it bases its figures is simply the innermost districts of the four Thames regions. “However there is a growing belief that the type of analysis offered by LHE is rapidly going to become where the goalposts will be placed as far as the London debate goes.”

- **1996**
  - As ministers rubber stamp 57 Trust opt-outs, LHE pamphlet analysing their dodgy finances gets national press coverage

- **1997**
  - Detailed survey of mental health services for health union COHSE highlights gaps in community-based care as beds close

- **1998**
  - Detailed LHE drafted reply to hospital rationalisation plan stirs debate in Barking and Havering

- **1999**
  - LHE and unions launch Londoners Need London’s Hospitals campaign to fight Tomlinson proposals to close ten hospitals and 4,000 beds

As ministers rubber stamp 57 Trust opt-outs, LHE pamphlet analysing their dodgy finances gets national press coverage

Detailed survey of mental health services for health union COHSE highlights gaps in community-based care as beds close

LHE opposes King’s Fund call to axe 5,000 beds in London’s hospitals

LHE infuriates government by leaking key findings of Tomlinson Report to national press the night before publication

LHE and unions launch Londoners Need London’s Hospitals campaign to fight Tomlinson proposals to close ten hospitals and 4,000 beds
Congratulations to London Health Emergency on 20 years campaigning:

- Against all cuts and closures in the NHS
- Against privatisation
- Against PFI
- For a publicly-owned, publicly funded health service
- For respect to all sections of staff in the NHS health care team

Organising Centre 020 8682 4224
www.respectatwork.org.uk
PFI projects push up bill to £1 billion: Manchester faces up to “unaffordable” capital programme

NHS chiefs throughout Greater Manchester will have to choose whether to build and refurbish the area’s hospitals and health facilities – or whether to meet national targets and National Service FRAMEwork, as set down by the government.

If they attempt to do both, then the £1 billion price tag that is being allocated to the NHS under government plans will fall short of requirements, plunging local Primary Care Trusts into financial stress which would add up to almost £100m in 2006-7, and peak at over £100m in 2008-9.

The cumulative shortfall across the region, which is being allocated to Manchester, could reach a staggering £723m by 2020.

That is the grim message from a confidential survey of the costs and implications of over 40 capital projects, with a total estimated cost of over £1 billion per annum, that are currently at various stages in the planning process. The survey, carried out by business consultants KPMG Strategic Health Authority, was commissioned by the Greater Manchester Health Authority, the SHA.

The SHA has obtained reports from all the project teams at work in the area on the revenue consequences of each of their schemes (which range in size from the giant £1.6bn hospital complex in Manchester, a £190m bundle of projects in Salford, and a new £150m hospital in Stockport to the £420m PFI project for a new hospital complex for Central Manchester hospital and Manchester Children’s Hospital Trust, under construction and likely to cost £1.3bn by 2010-11).

The SHA’s report, obtained at the end of January, was part of a series of confidential reports that were shared with all PCTs in Greater Manchester last summer to London Health Emergency on 20 years of campaigning.

NHS England, the SHA report said, has been set against a theoretical “public sector comparator” which would have meant none of the first dozen PFI hospital schemes would have go ahead as value for money, according to former minister Stephen Byers. The new formula is designed for a new formula of PFI: meeting the investment challenge.

The SHA report confirms that PFI schemes are the new Central Manchester hospital hospital complex cannot be afforded without wrecking other services in the area. This is a disturbing scenario in Manchester shows the folly of government policy, which, following a decade of disaster, underinvestment in hospitals and health services is now expecting to pull itself up with their own bootstraps, through the Private Finance Initiative, which hands the whole cost of capital and running to the public.

The SHA report claims that the scheme has been set against a projection of the likely increases in funding for each PCT, and the known pressures on the PCT’s budgets arising from cost inflation, existing commitments, and future plans and targets.

The SHA concludes that Greater Manchester will have to choose between capital schemes, NSF payments, and other investments. It warns: “Capital investment aspirations unaffordable both short and long-term, despite significant revenue growth. Choices need to be made between capital schemes, NSF payments, and other investments.”

Commenting on the findings, LHE’s Information Director John Lister said: “This disastrous scenario in Manchester shows the folly of government policy, which hands the whole cost of capital and running to the public, while expecting the public to pay for this through the Private Finance Initiative.”

The SHA report notes that the SHA report, obtained at the end of January, was part of a series of confidential reports that were shared with all PCTs in Greater Manchester last summer to London Health Emergency on 20 years of campaigning.

Big corridors … shame about the lack of office space: Swindon’s Great Western Hospital

THE SHAMBLES behind the glitzy glass facade of Swindon’s £122m PFI-funded Great Western Hospital, which opened last December is investigated in a new UNISON pamphlet, just published as we go to press.

Researched for the union by John Lister of LHE, the pamphlet – Not So Great – consists of an overview introduction, followed by interviews with front-line nursing, clerical and support staff.

The poor terms and conditions on offer to staff from Carillion, the company providing domestic, portering and catering services in the new hospital undermine the wider problem of the 2-tier workforce created in the first-wave PFI schemes.

The new pamphlet follows the successful formula of Voices from the front-line, published by UNISON earlier this year, which examined conditions and standards of care in 9 first-wave PFI hospitals.

In each case the question marks over the quality and value for money of support services is echoed by problems with the size of the building, its design and the poor quality finish to the fabric of the new hospital.

Despite early claims by supporters of the PFI scheme that a new purpose-built hospital would improve efficiency compared with the outdated, much-extended and altered Princess Margaret Hospital, it replaced, the Great Western is too small, and relying on portakabins and rented space in a supermarket for office space: it is currently building a number of extensions and add-on facilities.

Copies of both pamphlets are available from UNISON or from LHE.

More expensive than the Dome: £1 billion price tag on Paddington PFI folly

Project Paddington is a £2bn PFI project for a hospital complex for Central Manchester and Manchester Children’s Hospital Trust, under construction and likely to cost £1.3bn by 2010-11. It is one of the first dozen PFI hospital schemes that were pushed through by the government.

St Mary’s Hospital chief executive Julian Nettles was categorically denying that his hospital was being threatened with closure, as he launched a defense of the distribution of public money over 100 capital projects, with a total estimated cost of over £1 billion per annum, that are currently at various stages in the planning process. The survey, carried out by business consultants KPMG Strategic Health Authority, was commissioned by the Greater Manchester Health Authority, the SHA.

The SHA report claims that the scheme has been set against a projection of the likely increases in funding for each PCT, and the known pressures on the PCT’s budgets arising from cost inflation, existing commitments, and future plans and targets. The SHA concludes that Greater Manchester will have to choose between capital schemes, NSF payments, and other investments. It warns: “Capital investment aspirations unaffordable both short and long-term, despite significant revenue growth. Choices need to be made between capital schemes, NSF payments, and other investments.” Commenting on the findings, LHE’s Information Director John Lister said: “This disastrous scenario in Manchester shows the folly of government policy, which hands the whole cost of capital and running to the public, while expecting the public to pay for this through the Private Finance Initiative.”
Half of all mental health Trusts were in the red during the last financial year, and half had seen their budgets reduced in 2002-3 compared with the previous financial year. The findings of a survey by the Royal College of Psychiatrists show that three of the 49 Trusts whose medical directors responded had seen budget cuts of 5% or more, while the overall level of funding across all Trusts fell by 0.8% – at a time when mental health is supposedly a top priority service, and other sections of the NHS are seeing budgets increased.

The pattern of services has also been skewed by Trusts attempting to meet government targets by switching resources and staff from one part of the service to another – notably the expansion of assertive outreach and home treatment teams. The College’s research director Prof Paul Lelliott has warned that mental health Trusts are being obliged to make savings that help pay off deficits elsewhere in the NHS, while cash released from “efficiency savings” is “re-badged” to seem as if it is new money to meet NHS Plan targets.

This report followed one by the Sainsbury Centre for Mental Health which found that two thirds of the 18 Trusts whose finances were examined were running a deficit by the end of the last financial year, ranging from just £1,000 to £5 million.

The pressure group Rethink has claimed that of just over £1 billion announced as new spending on mental health since 1998 only around £750m is traceable as new money leaving the Department of Health, and much of this has vanished into the general pool of new money for the next of the NHS over the same period. Its chief executive, Cliff Prior says: “The picture is muddled and confused by double and triple cash counting, multiple public announcements of the same new money, the failure to transparently earmark all the extra funding as it is released and the backloading of spending plans to a “year three” that never seems to arrive.”

Berkshire Healthcare Trust has run up a deficit of almost £12m, and is planning to cut psychotherapy services and close a day centre as part of an emergency package of cuts to reduce the shortfall to £3.8m.

Mental health services in Glasgow are among those hit by a massive £11m cuts package carried through by the Greater Glasgow Health Board. Homelessness and alcohol projects are to be scrapped, and £1.5m lopped from mental health services. The Board claims implausibly that it still plans to put an extra £3m into children’s mental health teams next year.

The light of frail elderly patients marooned in hospital beds for lack of suitable nursing home accommodation or support for them to live at home has frequently been headline news. But a recent survey of delayed discharges from mental health beds, which revealed extensive delays resulting from a chronic shortage of supported housing facilities in London has attracted far less attention.

Scandal as patients wait months for discharge

More than half of the residents in 18 projects across just three London boroughs had been forced to wait at least a year before being discharged to supported accommodation; a third had waited up to six months.

In two of the boroughs housing shortages were so severe that some mental health clients were being placed outside the borough.

Problems included gaps in provision especially for those with special needs, and staff shortages among social workers and community psychiatric nurses, which undermine the continuity of care.

The joint report was produced by the Sainsbury Centre with the Greater London Authority, the Association of London Government and Advocacy Realty Works.

The findings confirm the picture of under-investment and neglect of this key area of psychiatric care that emerged from the UNISON 1999 survey ‘The Care Gap’, researched by LHE.

The report calls on the government to allocate funds that reflect London’s unique demands for mental health care: but the danger is that once again mental health will be fobbed off with warm words and more promises of investment which has yet to materialise.

Campaigning with LHE to keep mental health on the agenda

BRIAN LUMSDEN Secretary, LEE ROACH Chair
UNISON South London and Maudsley Health Branch
Union office, Bethlem Royal Hospital, Monks Orchard Rd, Beckenham, Kent BR3 3BX
New market-style reforms
Foundations of a financial flow fiasco

The government seems to be thumbing its nose at its supporters in the unions and across the country, and deliberately recreating the chaos and bureaucracy that caused such havoc in the Tory “internal market” – and which New Labour promised to end in 1997.

The Tories brought a grim legacy of spending cuts, bed closures, scaring waiting lists, privatisation of hospital ancillary services and of much care of the elderly.

This was followed in the 1990s by the mayhem and inefficiencies of a fragmented market system in which Trusts were forced to compete with each other, purchasers made life misery for providers and the wealthiest

NOC debts could knock back foundation bid

New questions are being asked over the viability of at least one foundation trust contender, Oxford’s Nuffield Orthopaedic Centre.

The NOC was an early applicant for Trust status, which it used to expand its private beds to make it one of the Trusts most dependent on income from private work, deriving over 10% of its income (almost £5m a year) from commercial work.

If the Trust does not resolve its financial deficit, it could lose one of the three stars it needs to qualify for Trust status. Four leading contenders for foundation status were ruled out of the running during the summer after losing 3-star status.

In an eerie echo of the

Emergency

London Health

Congratulations to London Health Emergency on 20 years campaigning to keep our public services public!

ANNIE HOLNESS, Chair
KEVIN O’BRIEN Secretary

UNISON
Epsom & St Helier Health Branch

Still campaigning against cuts and privatisation in the NHS, especially in the community and in mental health services.

Best wishes to London Health Emergency for your 20th Anniversary - and may you continue for many more years.

In solidarity ...
Caroline Bedale and Derrick Goold, Joint Branch Secretaries
Ruth Abraham and Karen Reissmann, Joint Branch Chairpersons

UNISON
MANCHESTER Community and Mental Health Branch
Beware “Genetically modified PFI”!

Don’t get into this doggy LIFT!

UNISON has branded the financing of primary health care facilities as “genetically modified PFI”.

A detailed pamphlet on “Local Initiative Finance Trusts” (LIFT) has been researched for union by the Democratic Health Network, and it sounds a warning to local campaigners that these schemes are on the up – and once set up, they will be a permanent fixture.

The first wave of LIFT schemes under discussion add up to £1 billion, two thirds of which comes directly from the private sector, which will remain a stake in each local project through a local company or Liftco.

60% of the shares and of the board in each Liftco will be held by associate sector investors, 20% by the Department of Health and its partly-owned pro-PFI organisation Partnerships UK, and 20% by local public sector “stakeholders” (such as Primary Care Trusts and local authorities).

But a long-term snag is that the public sector “partners” joining a Liftco have to sign a permanent “exclusivity agreement” – giving the new company the exclusive right to provide any new services or facilities in the area. This may require Lift to commit to a single project, but for a long period.

Disadvantages

Among the disadvantages of the new set-up is that it specifically aims to attract the interest of large commercial organisations – including those providing private health insurance, and pharmaceutical companies seeking new markets and outlets. This raises important issues about accountability and conflicts of interest.

But it’s not just the private sector getting its tango stuck into the juicy flesh of the NHS at primary care level: LIFT also transforms the public sector bodies involved, creating the potential for new conflicts of interest, and leaving the culture of public services to make primary care more like a business. As the pamphlet points out: “The creation of the Lift scheme also means that for the first time NHS and other public bodies will be directly held shares and directorships in companies that are operating for profit.”

But although many local public sector organisations appear to have accepted that Lift is the only show in town for financing new projects, other alternatives are being considered by some PCTs.

There are possibilities which do not involve a permanent privatisation of key primary care facilities: some areas could consider using the proceeds of land sales to fund a public sector alternative, or a partnership with non-profit or voluntary sector organisations instead.

The process of establishing a Lift scheme can easily take two years – but it is important that the assumptions and proposals are challenged from the beginning.

The public sector organisations will need to begin by drawing up a Strategic Services Development Plan; they then have to advertise for private sector partners, shortlist applicants, and select a preferred bidder. By this stage, any element of competition between private sector organisations has been eliminated: the preferred bidder is in a very strong position to secure favourable terms, knowing that if they pull out the public sector organisations will be left stranded.

New GP promises could be a nice little earner for corporate investors

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Disclosure

Local campaigners and unions should be demanding the fullest disclosure of anticipated costs of financing, profit margins, and the implications for any staff involved. They must demand full details of the costs and duration of any leases involved in the deal, a genuine comparison between these and existing costs, and evidence to show whether or not the scheme is affordable without damaging local services.

Wherever possible, campaigners will want to avoid local public sector organisations signing up to these schemes. This Lift does not take the NHS upwards, but down into the grimy world of private profit.

LIFT: A briefing for non-experts is available from UNISON.

H E A L T H E M E R G E N C Y

UNISON has branded the financing of primary health care facilities as “genetically modified PFI”.

A detailed pamphlet on “Local Initiative Finance Trusts” (LIFT) has been researched for union by the Democratic Health Network, and it sounds a warning to local campaigners that these schemes are on the up – and once set up, they will be a permanent fixture.

The first wave of LIFT schemes under discussion add up to £1 billion, two thirds of which comes directly from the private sector, which will remain a stake in each local project through a local company or Liftco.

60% of the shares and of the board in each Liftco will be held by associate sector investors, 20% by the Department of Health and its partly-owned pro-PFI organisation Partnerships UK, and 20% by local public sector “stakeholders” (such as Primary Care Trusts and local authorities).

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Mega PFI put on hold

Trust bosses at the giant Barts & The London hospitals in the East End have postponed a decision on which consortium should pick up the mega-contract for the PFI-funded rebuild of the Royal London Hospital in Whitechapel.

With refurbishment work at Barts’ Hospital, the scheme was last costed at a whopping £220 million-plus – and is certain to cost more before any final deal is signed.

Two consortia are in the frame for this, potentially the biggest hospital scheme in England –籼ka&以se & Renaissance.

But the City & Hackney CHC is complaining that in place of the open process of consultation which they had expected and asked for, the Trust has been holding closed meetings, with large amounts of information classed as “commercially sensitive.”

The decision, aptly described by the ILT chief executive as “one of the most important decisions the Trust will ever make,” will be taken at the end of October.

20 years on – and still campaigning!

AUTUMN 2003 HAS BROUGHT the 20th anniversary of London Health Emergency, and we are hoping to go into our third decade by stepping up the campaign against the restoration of the “internal market” system, Foundation Hospitals, PFI and privatisation in all its guises.

So it’s a big thanks to those union branches that have taken out adverts to help us fund this issue – and we urge all affiliated organisations to consider taking an advert in the next issue, at the end of the year. A full page is £480, 1/2 page £250, 1/4 page £130, 1/8 £70, 1/16 £35.

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We work with local campaigns and health union branches and regions all over England, Wales and Scotland, helping to draft responses to plans for cuts and closures, analyse local HA policies, design newspapers and flyers, and popularise the campaigning response.

The campaigning resources of Health Emergency depend upon affiliations and donations from organisations and individuals. If you have not already done so, affiliate your organisation for £10 per year, and £25 for larger organisations (over 500 members). Affiliates receive bundles (35 copies) of each issue of Health Emergency and other mailings. Additional copies of Health Emergency are available: bundles of 75 for £10 per year, and 150 for £20.

Affiliated organisations also get a generous discount on LHE publicity and consultancy services.

Health Emergency, launched in 1983, has remained in the forefront of the fight to defend the National Health Service against cuts and privatisation.